JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L. KEARNEY Policy No. H493029 H538069

1. I was residually disabled from 2/8 19 93 to present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation Not able to work as effectively. Not able to focus, travel as much or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 50 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on don't know 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166.00 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$2000.00	4	94	$2000.00	5	94	$2000	6	94

$2000.00 7/94 ; $2000 8/94 ; $2000 9/94; $2000.00 10/94

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 10/31 19 94 Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.